STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

December 18, 2009

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Dianne Abeloff, Esq.
NYS Department of Health
90 Church Street – 4th Floor
New York, New York 10007

Inho Kay, M.D.
Redacted Address

Charles C. Nicholas, Esq.
Chesney & Murphy, LLP
2305 Grand Avenue
Baldwin, New York 11510

RE: In the Matter of Inho Kay, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 09-220) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (McKinney Supp. 2007) and §230-c subdivisions 1 through 5, (McKinney Supp. 2007), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the Respondent or the Department may seek a review of a committee determination.

All notices of review must be served, by certified mail, upon the Administrative Review Board and the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

Redacted Signature

James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah

Enclosure

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

COPY

IN THE MATTER OF INHO KAY, M.D.	DETERMINATION AND ORDER
	BPMC #09-220

A Notice of Hearing and Statement of Charges, dated April 20, 2009, were served upon the Respondent, Inho Kay, M.D. **CAROLYN C. SNIPE, (Chair), WILLIAM M. BISORDI, M.D., AND PAUL F. TWIST, JR., D.O., R.P.A.,** duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(Executive) of the Public Health Law. **LARRY G. STORCH, ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer. The Department of Health appeared by Dianne Abeloff, Esq., Associate Counsel. The Respondent appeared by Chesney & Murphy, LLP, Charles C. Nicholas, Esq., of Counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

After consideration of the entire record, the Hearing Committee issues this Determination and Order.

PROCEDURAL HISTORY

Date of Service:	April 21, 2009
Answer Filed:	May 8, 2009
Pre-Hearing Conference:	May 21, 2009
Hearing Dates:	June 2, 2009 July 8, 2009 September 17, 2009
Witnesses for Petitioner:	Francine Yudkowitz, M.D.
Witnesses for Respondent:	Inho Kay, M.D. Elizabeth Frost, M.D.
Deliberations Held:	October 20, 2009

STATEMENT OF CASE

Petitioner has charged Respondent, an anesthesiologist, with six specifications of professional misconduct. The charges relate to the care and treatment rendered to three patients. The charges include allegations of gross negligence, in violation of N.Y. Education Law §6530(4), negligence on more than one occasion, in violation of N.Y. Education Law §6530(3) incompetence on more than one occasion, in violation of N.Y. Education Law §6530(5), and failure to maintain accurate medical records, in violation of N.Y. Education Law §6530(32). Respondent denied each and every allegation.

A copy of the Statement of Charges is attached to this Determination and Order in Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

Respondent

1. Inho Kay, M.D. (hereinafter "Respondent"), was authorized to practice medicine in New York State by the New York State Education Department's issuance of license number 181361 on or about February 2, 1990. (Not Contested).

2. Francine S. Yudkowitz, M.D. testified as an expert witness on behalf of Petitioner. Dr. Yudkowitz is board certified in pediatrics and anesthesiology, and is an associate professor of pediatrics and anesthesiology at the Mount Sinai School of Medicine. She is an attending physician at Mount Sinai Hospital in New York. (Ex. #5).

3. Elizabeth Frost, M.D. testified as an expert witness on behalf of Respondent. Dr. Frost is board certified in

anesthesiology and is a full professor of anesthesiology at the Mount Sinai School of Medicine. She is also an attending physician at Mount Sinai Hospital. (T. 525-527).

Patient A

4. On or about August 23, 2000, Patient A, a two year old female was scheduled to undergo surgical repair of a supracondylar fracture of humerus at Jamaica Hospital Medical Center. (Ex. #2).

5. Respondent performed a pre-anesthesia assessment of the patient. He documented the fact that the child had no known allergies, normal vitals, and a normal sinus rhythm. As part of his assessment he also noted that the patient had no loose teeth. (Ex. #2, p. 23).

6. Respondent observed that the child had no deformity of the chin or nose, and that the mouth appeared normal. The pre-anesthesia assessment was within the minimal standards of care. (T. 304,533-535).

7. Respondent induced anesthesia in Patient A with oxygen, nitrous oxide and sevoflurane, administered by mask and an Ambu bag. He used a laryngeal mask airway ("LMA"). (T. 312-313; Ex. #2, pp. 29-30).

8. There are three stages of inhalation induction. Stage one is when the patient is awake. Stage two, the

excitatory stage, occurs when the patient becomes atonic. Stage three is the surgical stage. Stage two is the time when airway troubles occur. (T. 37-39).

9. A laryngospasm occurs when the vocal cords close together. There is no way for oxygen or the inhalation agent to get into the lungs. This a potentially life threatening occurrence. (T. 41, 114).

10. An anesthesiologist must be able to recognize and treat the symptoms of a laryngospasm. A patient experiencing a laryngospasm will gag or cough, and secretions may be seen. (T. 41, 114-115, 121, 322).

11. The anesthesia began at 18:30. At the beginning of the procedure, the surgeon accidentally pulled the patient's IV line out while trying to untangle the line. After administering a few breaths of the gas mixture, Respondent felt some resistance. He tried more pressure, but after five or six breaths, the resistance continued. (T. 312-313, 327; Ex. #2, p. 29).

12. It is very rare to experience such resistance in a young child. (313-314).

13. Respondent checked the patient's mouth and found no aspiration or foreign body. The patient did not gag or cough. Respondent replaced the LMA, but still experienced

resistance. Approximately thirty seconds elapsed. Respondent immediately called for assistance. (T. 318, 323).

14. Dr. Morisco and Dr. Vaval came to the operation room to assist. Both were senior anesthesiologists at the hospital. Approximately two to three minutes had elapsed since Respondent experienced difficult ventilating the patient. (T. 318-319).

15. Dr. Morisco established a new IV line. The patient developed bradycardia. Respondent administered Atropine by intramuscular injection at 1840, 1845 and 1850 hours. A code was called. A vascular surgeon was called to establish another IV line, and Respondent intubated the patient. (T. 323-324; Ex. #2, pp, 20, 29-30).

16. The intubation was easily performed. The patient's ventilation immediately improved. Her cardiac activity was restored, and her oxygen saturation went into the high 90% range. (Ex. #2, pp. 20, 29-30).

17. The fact that Respondent was able to intubate without difficulty indicates that either the patient did not experience a laryngospasm, or that it had already passed. (T. 324-325, 552-553).

18. The anesthesia record needs to accurately report the actions of the physician and the condition of the patient. (T. 82-87).

19. Respondent's anesthesia record for Patient A forces subsequent providers to guess why certain actions were taken since there is either no explanation or support in the record for those actions. For example, Respondent administered Atropine to treat bradycardia three times, at 18:40, 18:45 and 18:50. However, the graphical portion of the anesthesia record reflects a patient experiencing tachycardia at that time. (Ex. # 2, p. 29).

20. Respondent noted that he had difficulty ventilating the patient. However, he recorded normal end-tidal CO_2 values. The end-tidal values should be elevated if Respondent was having difficulty ventilating. (T.71; Ex. #2, p. 29).

21. The anesthesia record also notes that the oxygen saturation level was 100%. This is not consistent with a patient having trouble ventilating. Similarly, the patient is noted to have normal blood pressure and heart rates. This is inconsistent with a patient requiring cardiopulmonary resuscitation. (T. 70, 76, 77, 80-82; Ex. #2, p. 29).

22. An anesthesiologist cannot be reasonably expected to complete the medical record while dealing with a complication. However, he is expected to retrospectively complete the record and accurately record all significant information. If there is a complication which occurs over time, the physician should include a separate note on the anesthesia record, if there is room. Alternatively, he should write a progress note describing in detail the events which occurred in the operating room. (T. 85-86, 169).

23. Respondent's records for Patient A do not accurately reflect what occurred in the operating room. (T. 92-93, 564; Ex. #2).

Patient B

24. On or about march 18, 2003, Patient B, a thirty-four year old female, underwent an endoscopic retrograde cholangiopancreatography ("ERCP") at Jamaica Hospital Medical Center. (Ex. #3).

25. Dr. Krasienko was the anesthesiologist assigned to this case. Dr. Krasienko's pre-anesthesia workup noted the patient's weight at 175lbs. Her EKG noted a normal sinus rhythm with a first degree A-V block, and a septal infarct, age undetermined. Dr. Krasienko recorded the patient as ASA class II on the anesthesia record. (Ex. #3, pp. 24, 37).

26. Dr. Krasienko began anesthesia at 11:05 a.m. She administered two doses of Midazolam (Versed) 2 milligrams each, and placed the patient on a Propofol (Diprivan) infusion at a rate of 10 milligrams per minute. (T. 177; Ex.#3, p. 37).

27. The patient was not adequately sedated, and Dr. Krasienko called for help. Respondent was sent to the endoscopy suite by Dr. Vaval. Dr. Vaval told Respondent that there was a problem in the endoscopy suite, and directed him to solve the problem. When Respondent arrived at the suite, he was not expecting to have to take over the case. (T. 427; Ex. #3).

28. Dr. Krasienko informed Respondent that the patient was not adequately anesthetized and the gastroenterologist was complaining. Dr. Krasienko told Respondent that Patient B didn't have any history of medical problems. (T. 439-440).

29. In fact, Patient B had a history of crack cocaine abuse and was a resident of an inpatient drug rehabilitation facility. (T. 439-441).

30. At 11:20 a.m., Dr. Krasienko left the endoscopy suite, turning the case over to Respondent. (Ex. #3).

31. When Respondent took over anesthesia management of Patient B, the patient was sitting up on the table. She asked him whether he was married, and whether he had any children. He told her that they could discuss that later. He asked her to lie in a prone position. When she complied, he began to administer anesthesia. (T. 446).

32. Respondent administered Fentanyl (a narcotic) 50 micrograms IV, and restarted the Propofol drip. The gastroenterologist then attempted to restart the ERCP at 11:30 a.m. by introducing the scope. (T. 447-448; Ex. #3, pp. 23, 37).

33. The patient was still moving her head and neck, making it impossible to proceed. Respondent then administered a Propofol bolus of 50 milligrams (5cc) IV. (T. 448; Ex. #3, p. 37).

34. The gastroenterologist then restarted the procedure. Approximately 5 minutes later, the patient's oxygen saturation dropped to 80%. Respondent repositioned the pulse oximeter, and lifted the patient's chin. The patient's oxygen saturation then returned to 100%. (T. 451-453; Ex. #3, p. 37).

35. Shortly thereafter, Patient B developed bradycardia. Her pulse rate dropped from 57 to 48 beats per

minute. At 11:35 a.m., Respondent administered 0.4 milligrams of Atropine IV to raise the heart rate. The heart rate rose to 68 beats per minute. (T. 454-455; Ex. #3, p. 37).

36. Two minutes later (11:37 a.m.), the patient again developed bradycardia, and the oxygen saturation dropped. Respondent adjusted the pulse oximeter and lifted the patient's chin. The oxygen saturation returned to normal, but the pulse remained slow. (T. 455-456; Ex. #3, p. 37).

37. The patient continued to breathe on her own, albeit shallowly. This indicated that her airway was clear, but that her respiratory function was depressed. Respondent administered medication to reverse the anesthesia and improve the patient's breathing. He administered 0.1 milligrams of Narcan to counteract the Fentanyl, and 0.2 milligrams of Romazicon (Flumazenil) to counteract the Versed. It took approximately 15 to 20 seconds to administer these medications. (T. 456; Ex. #3, p.37).

38. On the anesthesia record, it appears that Respondent noted 2 milligrams of Romazicon. However, the drug comes in 0.2 milligram ampules. Respondent would have had to open and use ten ampules of the drug to administer that much Romazicon to Patient B. (T. 473-474; Ex. #3, p. 37).

39. When the patient's condition did not immediately improve, Respondent decided to intubate her. He called a code and directed the gastroenterologist to withdraw the endoscope. He turned the patient from her belly into the supine position. (T. 462-467; Ex. #3, p. 27).

40. Respondent gave two breaths to the patient with mouth to mouth breathing, and then ventilated her with a mask and Ambu Bag. (T. 467).

41. Respondent took a laryngoscope from the code cart and attempted to intubate Patient B. The laryngoscope light did not work, making it impossible to visualize the larynx. A second scope was brought to Respondent, and he was then able to intubate the patient. (T. 467-471; Ex. #3, p. 27).

Patient C

42. On January 6, 2006, Patient C, a 69 year old female, presented at the Island Eye Center, Carle Place, New York, for cataract surgery on her left eye. Respondent provided anesthesia management for Patient C. (Ex. #4).

43. As Respondent was preparing to sedate Patient C and inject her left eye, he noticed that the patient in the next bed was in distress. (T. 503-504).

44. Respondent observed that this other patient was developing vasovagal syncope. He called for nursing

assistance, and briefly attended to this patient. He then returned his attention to Patient C. (T. 504).

45. Respondent failed to properly orient himself to Patient C before he began to perform a peribulbar block on her right eye. He administered 3-4 ccs of anesthetic in the right eye before he realized his error. He then withdrew the needle, prepared and administered the full amount of anesthetic into the correct (left) eye, and notified the surgeon of his error. (T. 505-508; Ex. #4, p. 26).

46. Respondent fully documented his error, and informed the patient and her husband following the surgery. (T. 508-510; Ex. #4, p. 26).

CONCLUSIONS OF LAW

Respondent is charged with six specifications of professional misconduct. The charges relate to the care and treatment rendered to three patients. The charges include allegations of gross negligence, in violation of N.Y. Education Law §6530(4), negligence on more than one occasion, in violation of N.Y. Education Law §6530(3) incompetence on more than one occasion, in violation of N.Y. Education Law §6530(5), and failure to maintain accurate medical records, in violation of N.Y. Education Law §6530(32).

This statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law" sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence, and the fraudulent practice of medicine.

The following definitions were utilized by the Hearing Committee during its deliberations:

Negligence is the failure to exercise the care that a reasonably prudent physician would exercise under the circumstances. It involves a deviation from acceptable standards in the treatment of patients. Bogdan v. Med. Conduct Bd., 195 A. D. 2d 86, 88-89 (3rd Dept. 1993). Injury, damages, proximate cause, and foreseeable risk of injury are not essential elements in a medical disciplinary proceeding, the purpose of which is solely to protect the welfare of patients dealing with State-licensed practitioners. Id.

Gross Negligence is negligence that is egregious, i.e., negligence involving a serious or significant deviation

from acceptable medical standards that creates the risk of potentially grave consequence to the patient. Post v. New York State Department of Health, 245 A.D. 2d 985, 986 (3rd Dept. 1997); Minielly v. Commissioner of Health, 222 A.D. 2d 750, 751-752 (3rd Dept. 1995).

Incompetence is a lack of the requisite knowledge or skill necessary to practice medicine safely. Dhabuwala v. State Board for Professional Medical Conduct, 225 A.D.2d 209, 213 (3rd Dept. 1996).

The other charged specifications of misconduct allege the failure to maintain records which accurately reflect the care and treatment of the patient, in violation of N.Y. Education Law §6530(32). The Hearing Committee interpreted this statute in light of the usual and commonly understood meaning of the underlying language. (*See*, New York Statutes, §232).

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee made the following conclusions of law pursuant to the factual findings listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

The Hearing Committee first considered the credibility of the various witnesses, and thus the weight to be accorded their testimony. The Department presented testimony by Francine

S. Yudkowitz, M.D. Dr. Yudkowitz is board certified in anesthesiology and pediatrics. Dr. Yudkowitz is an associate professor of anesthesiology and pediatrics at the Mount Sinai School of Medicine, and an attending physician in both specialties at Mount Sinai Hospital. (Ex. #5). The Committee found her to be a highly competent and credible expert witness.

Respondent presented testimony by Elizabeth Frost, M.D. Dr. Frost is a full professor of anesthesiology at the Mount Sinai School of Medicine and an attending physician at Mount Sinai Hospital. Dr. Frost is a highly skilled and competent anesthesiologist, with an extensive academic bibliography. (T. 525-530). The Committee also found Dr. Frost to be a very credible witness.

Respondent also testified on his own behalf. He obviously has a great stake in the outcome of these proceedings, and the Committee evaluated his testimony accordingly. While denying that his care of Patients A and B was inappropriate, Respondent freely admitted that he erred by anesthetizing the wrong eye for Patient C. The Committee unanimously concluded that Respondent is a highly experienced and knowledgeable anesthesiologist, and found his testimony to be credible.

Both experts testified that the anesthesia techniques and agents employed by Respondent for Patients A and B were well

within the standard of care. The core of the Department's narrowly drawn case is the allegation that Respondent failed to recognize and treat potentially lethal complications in a timely manner. The Department alleged that Respondent failed to recognize and treat a laryngospasm in Patient A, and failed to recognize and treat Patient B's hypoxia in a timely manner.

The Hearing Committee was struck by the fact that two highly skilled anesthesiologists on the faculty of the same medical school came to diametrically opposed conclusions regarding the decisions made by Respondent during these two crises in the operating room. This leads us to the conclusion that there is not one definitive course of action to be taken under the circumstances presented by these cases. It is a matter of professional judgment, as exercised by the clinician on the scene.

The Department has the burden of proving each of the allegations and specifications of misconduct by a preponderance of the evidence. Based upon our analysis of the evidence and testimony, we conclude that, with one exception noted below, the Department has failed to meet its burden.

Patient A

Patient A was a two year old female admitted for surgical repair of a fractured arm. The Department alleged that

Respondent failed to examine her airway as part of his preoperative assessment. The evidence established that this young child was in distress and crying. Respondent did a general assessment of her mouth, but was not able to perform a thorough examination due to the child's agitation.

Both Dr. Frost and Dr. Yudkowitz agreed that it can be difficult to assess a child's airway under these circumstances. Moreover, Dr. Yudkowitz admitted that the inability to perform a complete examination had no bearing on the outcome of this case. Accordingly, the Hearing Committee voted to dismiss Factual Allegation A.1.

Factual Allegation A.2, which alleged that Respondent failed to place necessary monitors on Patient A, was withdrawn by the Department following the end of testimony.

The Department also alleged that Respondent failed to recognize and treat a laryngospasm in a timely manner. The evidence established that after sedating Patient A, Respondent began to ventilate the patient with a laryngeal mask airway (LMA) and an Ambu bag. Both Dr. Frost and Dr. Yudkowitz agreed that this was an appropriate course of action for a brief operation such as was contemplated for Patient A.

Almost immediately after administering the anesthetic gas, Respondent encountered resistance while ventilating the

patient. This is a very rare occurrence in a young child. He checked her mouth for aspiration or a foreign body and found none. He quickly tried a second LMA, and when the resistance continued, Respondent called for assistance.

Two senior anesthesiologists on the hospital staff came in to the OR to assist. Respondent intubated Patient A, and administered Atropine to address her developing bradycardia. Dr. Yudkowitz opined that the patient experienced a laryngospasm, and Respondent should have administered Succinylcholine to break the spasm.

Respondent noted that he entertained several possible causes for the resistance, including laryngospasm, bronchospasm, or pulmonary embolism. Dr. Frost noted that the fact the patient was easily intubated indicates that a laryngospasm was not present, or had already resolved. She also testified that Succinylcholine was not the drug of choice under the circumstances.

It is apparent to this Hearing Committee that Respondent certainly recognized that the patient was in distress and took steps to resolve the problem. The decision as to which drugs to administer and in what order appears to be a matter of clinical judgment. Under the circumstances the Committee declined to conclude that Respondent failed to recognize and

treat a laryngospasm in a timely manner. Accordingly, the Committee voted to dismiss Factual Allegation A.3. The Committee further voted to dismiss the First Specification of professional misconduct as well as the Third Specification as it relates to Patient A. Insofar as no evidence was presented that Respondent lacked the skills and knowledge necessary to practice anesthesiology, the Committee voted to dismiss the Fourth Specification, as it relates to Patient A.

The remaining allegation raised regarding Respondent's management of Patient A concerns the anesthesia record. There are a number of discrepancies in the anesthesia record as compared to the nursing notes which make it difficult to ascertain precisely what occurred and in what sequence events unfolded. It is understandable that during a crisis the physician must place priority on attending the patient, rather than contemporaneously updating the chart. However, Respondent should have written a progress note afterwards to complete the record. His failure to do so was a deviation from accepted standards of practice. Accordingly, the Committee voted to sustain Factual Allegation A.4, and the Fifth Specification of professional misconduct set forth in the State of Charges.

Patient B

Patient B was a 34 year old female who was in the endoscopy suite to undergo an ERCP procedure. At the outset, we note that Respondent was not initially involved in the anesthesia management for this patient. Dr. Krasienko, another anesthesiologist on the staff at Jamaica Hospital Medical Center was in attendance. Dr. Krasienko performed the pre-anesthesia workup and determined to proceed with IV sedation. Dr. Krasienko administered two doses of Versed (2 milligrams) and placed the patient on a Propofol infusion at a rate of 10 milligrams per minute.

Respondent was called down to the endoscopy suite after Dr. Krasienko was unable to adequately anesthetize Patient B. When Respondent arrived on the scene, the patient was sitting up on the table. Dr. Krasienko gave Respondent a brief review of the case and then left. It appears that she did not convey some significant history regarding the patient. Specifically, she did not mention Patient B's history of drug abuse.

Insofar as the gastroenterologist wanted to proceed with the ERCP, Respondent re-started the Propofol infusion, and administered Fentanyl. When the patient failed to become sedated, he added a 50 milligram bolus of Propofol. Both Drs.

Yudkowitz and Frost agreed that the method of anesthesia, and doses thereof, were within accepted standards of practice.

The Department alleged that Respondent failed to recognize and treat Patient B's hypoxia in a timely manner. Approximately five minutes after the procedure was re-started, the patient's oxygen saturation dropped. Respondent repositioned the pulse oximeter and lifted the patient's chin. The oxygen saturation then immediately returned to normal. The patient had a decrease in heart rate, which Respondent addressed with Atropine. When the patient's oxygen saturation dropped again, and the bradycardia returned, Respondent called for assistance and moved to intubate the patient. He quickly administered reversal agents, and began mouth to mouth breathing. He attempted to intubate the patient, but the laryngoscope in the room did not function properly. He had to call for another scope to be brought to the room.

The experts differed as to whether Respondent should have intubated Patient B before or after administering the reversal agents. Nevertheless, it is clear that Respondent did recognize the patient's developing hypoxia, and took steps to address the condition. Accordingly, the Committee voted to dismiss Factual Allegation B.1.

The second Factual Allegation charges that Respondent administered an inappropriate dose of Flumazenil (Romazicon)- a reversal agent for Versed. The anesthesia record seems to indicate that a 2 milligram dose was administered. This would be 10 times the recommended dose. Respondent testified that he only administered 0.2 milligrams. He noted that the drug comes in 0.2 milligram ampules, and he would have had to open and use 10 ampules to administer that large a dose. We find it more likely that Respondent either miswrote the amount, or that it is an artifact of the photocopying process (the Department does not provide the original medical records in OPMC proceedings). As a result, the Committee voted to dismiss Factual Allegation B.2. The Committee also voted to dismiss the Second Specification, as well as the Third Specification, as it relates to Patient B.

Factual Allegation B.3 was withdrawn by the Department during the hearing. The last factual allegation regarding Patient B, charged Respondent with failing to maintain an accurate record for this patient. The Hearing Committee unanimously concluded that the anesthesia record for Patient B reflects an accurate representation of the care rendered by Respondent, and voted to dismiss Factual Allegation B.4. The Committee further voted to dismiss the Fourth and Sixth

Specifications of professional misconduct as they relate to Patient B.

Patient C

The sole allegation raised concerning Patient C is that Respondent performed a peribulbar block on the incorrect eye. The evidence established, and Respondent freely admitted, that he began to inject the right eye, instead of the left. Respondent's attention was diverted when the patient in an adjoining area began to show signs of distress. He turned away to assist that other patient. When he returned to Patient C, he failed to take the time to properly re-orient himself to the patient. As a result, he began to anesthetize the wrong eye. He quickly recognized his error, and injected the proper eye. He informed the surgeon, fully documented the error in the chart, and informed the patient and her family. Respondent also kept the patient under observation for an extended period in the recovery room to ensure that the right eye was fully recovered and followed up with the patient at home.

Based on the above, the Committee voted to sustain Factual Allegation C.1. The Committee further concluded that a reasonably prudent anesthesiologist under the circumstances would have taken the time to get re-oriented to the patient before proceeding with the anesthesia. Respondent's failure in

this regard constitutes negligence. However, a single act of negligence does not rise to the level of professional misconduct under N.Y. Education Law §6530(3). As noted above, the Committee dismissed the specifications of negligence and gross negligence relating to Patients A and B. Therefore, the Committee voted to dismiss the Third Specification, which alleged negligence on more than one occasion.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, determined that Respondent shall be placed on probation for a period of one year. During the period of probation, Respondent's medical records shall be monitored to verify compliance with accepted standards of practice. In addition, Respondent shall be required to attend two continuing medical education courses, acceptable to the Director of the Office of Professional Medical Conduct, on medical-recordkeeping practices. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The only specification of professional misconduct which we have sustained involved inadequate record-keeping. The Committee believes that a period of probation, with monitoring of Respondent's record-keeping practices, is an appropriate sanction under the totality of the circumstances.

ORDER

Based upon the foregoing, **IT IS HEREBY ORDERED THAT:**

1. The Fifth Specification of professional misconduct, as set forth in the Statement of Charges is **SUSTAINED**;

2. The First through Fourth, and the Sixth Specifications of professional misconduct, as set forth in the Statement of Charges are **DISMISSED**;

3. Respondent be placed on probation for a period of one (1) year from the effective date of this Determination and Order. The complete terms of probation are attached to this Determination and Order in Appendix II and are incorporated herein;

4. This Determination and Order shall be effective upon service. Service shall be either by certified mail upon Respondent at Respondent's last known address and such service shall be effective upon receipt or seven days after mailing by

certified mail, whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: Great Neck, New York
12/ 17 **,2009**

Redacted Signature

CAROLYN C. SNIPE (CHAIR)

WILLIAM M. BISORDI, M.D.
PAUL F. TWIST, JR., D.O.

TO: Dianne Abeloff, Esq.
Associate Counsel
New York State Department of Health
90 Church Street - 4th Floor
New York, New York 10007

Inho Kay, M.D.

Redacted Address

Charles C. Nicholas, Esq.
Chesney & Murphy, LLP
2305 Grand Avenue
Baldwin, New York 11510

APPENDIX I

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER OF INHO KAY, M.D.	STATEMENT OF CHARGES

INHO KAY, M.D., the Respondent, was authorized to practice medicine in New York State on or about February 2, 1990, by the issuance of license number 181361 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about August 23, 2000, Patient A (the identity of the patients is contained in the attached Appendix) was scheduled to undergo surgical repair of her supracondylar fracture of her humerus. Respondent performed the pre-operative anesthesia assessment and administered the anesthesia. Respondent's care and treatment of Patient A deviated from accepted medical conduct, in that Respondent:

1. Failed to examine Patient A's airway during the preoperative assessment;

2. ~~Failed to place necessary monitors on Patient A~~;

withdrawn by Petitioner 10/14/2009

3. Failed to recognize and treat a laryngospasm in a timely manner;

4. Failed to maintain an anesthesia record that accurately reflects

the patient's condition and the care and treatment rendered by Respondent to Patient A.

B. On or about March 18, 2003, Patient B underwent an endoscopic retrograde cholangiopancreatography. Respondent assumed the anesthesia care from another anesthesiologist. Respondent's care and treatment of Patient B deviated from accepted medical conduct, in that Respondent;

1. Failed to recognize and treat Patient B's hypoxia in a timely manner;

2. Administered an inappropriate dose of Flumazenil;

withdrawn by Dept. 06/02/2009

~~3. Failed to ensure that resucitative equipment was functional~~;

4. Failed to maintain an anesthesia record that accurately reflects the patient's condition and the care and treatment rendered by Respondent to Patient B.

C. On or about January 6, 2006, Patient C went for cataract surgery on her left eye. Respondent administered the anesthesia. Respondent's care and treatment of Patient C deviated from accepted medical standards, in that Respondent:

1. Performed a peribulbar block on the incorrect eye.

SPECIFICATION OF CHARGES

FIRST THROUGH THIRD SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

1. Paragraph A and its subparagraphs;
2. Paragraph B and its subparagraphs;

FOURTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

3. Paragraph A and its subparagraphs; Paragraph B and its subparagraphs; and/or Paragraph C and its subparagraphs.

FIFTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

4. Paragraph A and its subparagraphs; Paragraph B and its

subparagraphs; and/or Paragraph C and its subparagraphs.

SIXTH THROUGH SEVENTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

5. Paragraph A and A4;
6. Paragraph B and B4.

DATE: April 20, 2009
New York, New York

Redacted Signature

ROY NEMERSON
Deputy Counsel
Bureau of Professional Medical Conduct

APPENDIX II

Terms of Probation

1. Respondent shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his profession.

2. Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street Suite 303, Troy, New York 12180-2299; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.

3. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.

4. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by New York State. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law section 171(27)]; State Finance Law section 18; CPLR section 5001; Executive Law section 32].

5. The period of probation shall be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation which were not fulfilled shall be fulfilled upon Respondent's return to practice in New York State.

6. Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and his staff at practice locations or OPMC offices.

7. Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.

8. Respondent shall enroll in and complete two continuing education programs in the area of medical record-keeping . Said continuing education programs shall be subject to the prior written approval of the Director of OPMC and be completed within the year of probation.

9. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he is subject pursuant to the Order and shall assume and bear all costs related to compliance. Upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding and/or any such other proceeding against Respondent as may be authorized pursuant to the law.